Health and Dental Benefits Comparison –
Plan Year July 1, 2015 – June 30, 2016
JCC, FR, FO, FL, BOS,COURTHOUSE and 30 HOUR EMPLOYEES

Plans	Coverage Type	Total Premium	HSA Employer Contribution	Total Plan Costs	Employee Pays Per Month
CONSUMER DRIVEN HEALTH PLAN – with Health Savings Account HealthKeepers Point of Service Plan (POS)	Employee Dual Family	$434.00 $912.00 $1,277.00	$125.00 $125.00 $125.00	$559.00 $1,037.00 $1,402.00	$44.00 $137.00 $192.00
CONSUMER DRIVEN HEALTH PLAN – with Health Savings Account Optima Point of Service Plan (POS)	Employee Dual Family	$434.00 $912.00 $1,277.00	$125.00 $125.00 $125.00	$559.00 $1,037.00 $1,402.00	$44.00 $137.00 $192.00
Delta Dental PPO Plus Premier Plan 1	Employee Dual Family	$22.00 $41.00 $65.00	Not applicable	$22.00 $41.00 $65.00	$2.00 $5.00 $10.00
DeltaCare DHMO	Employee Dual Family	$27.00 $52.00 $82.00	Not applicable	$27.00 $52.00 $82.00	$6.00 $15.00 $25.00
Delta Dental PPO Plus Premier Plan 2	Employee Dual Family	$33.00 $59.00 $85.00	Not applicable	$33.00 $59.00 $85.00	$12.00 $23.00 $30.00

CONSUMER DRIVEN HEALTH PLANS

AC = Allowable Charge	Anthem HealthKeepers Lumenos GHSA573 (POS – Open Access)	Optima Equity Vantage 3000/100% (POS – Open Access)
Pre-Existing Condition Waiting Period	None	None
Dependent Coverage to the end of Calendar Year	Until age 26	Until age 26
Out of Area Coverage	Emergency & Urgent care; may choose PCP in other location; special program if living out of state	Out of area dependent rider (enrollment required) Emergency & Urgent care only
Out of Network	Covered at 70% [AC] after $$6,000/$12,000 out of network deductible	Covered at 70% [AC] after $$6,000/$12,000 out of network deductible
	In Network	**In Network**
Open Access	No referral needed to see specialist	No referral needed to see specialist
Deductible per Year	$3,000/person $6,000/family	$3,000/person $6,000/family
Out of Pocket Maximum per Year	$4,000/person $8,000/family	$4,000/person $8,000/family
Physician Services		
Preventive Wellness Visits and Well Baby Visits	$0 copay then covered at 100%	$0 copay then covered at 100%
PCP Office Visit	Covered at 100% after deductible	Covered at 100% after deductible
Specialist Office Visit	Covered at 100% after deductible	Covered at 100% after deductible

CONSUMER DRIVEN HEALTH PLANS

AC = Allowable Charge	Anthem HealthKeepers Lumenos GHSA573 (POS – Open Access)	Optima Equity Vantage 3000/100% (POS – Open Access)
	In Network	**In Network**
Spinal Manipulation (Chiropractic Care Services)	Covered at 100% after deductible	Covered at 100% after deductible
Lab, X-ray, Ultrasound and Diagnostic	Covered at 100% after deductible	Covered at 100% after deductible
MRI, MRA, CT, CTA and PET scans – regardless of location	Covered at 100% after deductible	Covered at 100% after deductible
Physical, Occupational and Other Therapy	Covered at 100% after deductible	Covered at 100% after deductible
Maternity	Covered at 100% after deductible	Covered at 100% after deductible
Hospital Services		
Ambulance Services	Covered at 100% after deductible	Covered at 100% after deductible
Outpatient Surgery	Covered at 100% after deductible	Covered at 100% after deductible
Inpatient Care	Covered at 100% after deductible	Covered at 100% after deductible
Emergency Room and Physician	Covered at 100% after deductible	Covered at 100% after deductible
Urgent Care Center	Covered at 100% after deductible	Covered at 100% after deductible
Mental Health and Substance Abuse Services		
Inpatient	Covered at 100% after deductible	Covered at 100% after deductible
Outpatient	Covered at 100% after deductible	Covered at 100% after deductible

CONSUMER DRIVEN HEALTH PLANS

AC = Allowable Charge	Anthem HealthKeepers Lumenos GHSA573 (POS – Open Access)	Optima Equity Vantage 3000/100% (POS – Open Access)
	In Network	**In Network**
Preventive		
Vision	$15 copay ; no deductible	$0 copay; no deductible
Well Baby	$0 copay then covered at 100%	$0 copay then covered at 100%
Annual Physical	$0 copay then covered at 100%	$0 copay then covered at 100%
Prescription Drug Benefits		
Retail 31-day supply	Tier 1: Selected Generic: $15 copay Tier 2: Selected Brand and Other Generic: $40 copay Tier 3: Non-Selected Brand: $75 copay Tier 4 Specialty Drugs: 20% up to $200	Tier 1: Selected Generic: $15 copay Tier 2: Selected Brand and Other Generic: $40 copay Tier 3: Non-Selected Brand: $75 copay Tier 4 Specialty Drugs: 20% up to $200
Mail Order 90-day supply	Tier 1: Selected Generic: $38 copay Tier 2: Selected Brand and Other Generic: $100 copay Tier 3: Non-Selected Brand: $188 copay Tier 4: Specialty Drugs 20% up to $400	Tier 1: Selected Generic: $38 copay Tier 2: Selected Brand and Other Generic: $100 copay Tier 3: Non-Selected Brand: $188 copay Tier 4: Specialty Drugs N/A

Dental Options - This is a brief comparison. For more information and limits, consult the fee schedule, plan summary and/or evidence of coverage.

UCR = Usual, Customary and Reasonable Charge	DeltaCare DHMO	Delta Dental PPO Plus Premier Plan 1	Delta Dental PPO Plus Premier Plan 2
Type	Managed Care	Fee for Service	Fee for Service
Dentist Choice	From Panel	Any; Maximum benefit if participating PPO or Premier Network dentist	
Deductible per Contract Year	None	$25/person per patient $75/family per contract year Diagnostic & Preventive services exempt	$75/person per patient $225/family per contract year Diagnostic & Preventive services exempt
Maximum Benefit Amount per Contract Year	No limit	$1,000/person	$1,000/person (Diagnostic & Preventative Services do not count towards maximum per contract year)
Diagnostic & Preventive Services			
Oral Exam & Cleaning (2x/yr)	100%	100% UCR	100% UCR
X-rays (bitewings 1x/yr; full mouth 1x/3yrs)	100%	100% UCR	100% UCR
Sealants (age 16 & under)	See fee copay schedule	100% UCR	100% UCR
Basic Services			
Fillings	See fee copay schedule	90% PPO dentist after deductible 80% UCR Premier dentist after deductible	90% PPO dentist after deductible 80% UCR Premier dentist after deductible
Oral Surgery & Extractions	See fee copay schedule	90% PPO dentist after deductible 80% UCR Premier dentist after deductible	90% PPO dentist after deductible 80% UCR Premier dentist after deductible
Endodontics/ Periodontics	See fee copay schedule	90% PPO dentist after deductible 80% UCR Premier dentist after deductible	90% PPO dentist after deductible 80% UCR Premier dentist after deductible
Denture Repair/ Recementation	See fee copay schedule	90% PPO dentist after deductible 80% UCR Premier dentist after deductible	90% PPO dentist after deductible 80% UCR Premier dentist after deductible
Major Services			
Crowns	See fee copay schedule	Not Covered	60% PPO dentist after deductible 50% UCR Premier dentist after deductible
Prosthetic Coverage	See fee copay schedule	Not Covered	60% PPO dentist after deductible 50% UCR Premier dentist after deductible
Orthodontics (age 19 and under)	See fee copay schedule	Not Covered	50% UCR $1,000/lifetime maximum
Implants	Not Covered	Not Covered	60% PPO dentist after deductible 50% UCR Premier dentist after deductible